What should happen after the death of a probationer? Learning from suicide investigations in prison.

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What should happen after the death of a probationer? Learning from suicide investigations in prison

This comment piece uses Phillipa Tomczak's (2019) recent book *Prison Suicide: what happens afterwards* to consider the issue of self-inflicted deaths amongst people under probation supervision. Although the book is focused on suicides in prison, I argue that it has a great deal of relevance for our understanding of suicides amongst people on probation and what should be done after a suicide of someone on the caseload. I begin with an overview of the book, its underpinning research and overarching argument and then reflect on how we can apply Tomczak's findings to the probation context. This commentary is based on my own research in the area of deaths after prison and under probation supervision in which we have argued that these deaths are neglected, especially when compared to prison deaths (Phillips et al., 2019b). We have also highlighted high rates of self-inflicted deaths amongst people on probation. People on probation are 8.67 times more likely to die by suicide than people in the general population and 1.42 times more likely to die by suicide than people in prison (Phillips et al., 2018). Whilst acknowledging the fact that deaths in prison are different to deaths in the community, there are some important lessons from prison for those of us working and researching this topic in the context of probation.

The book begins with an overview what we already know about suicides in prison. It provides an overview of the reasons for suicide - taking on both individual and structural factors - and explores what is done to prevent suicide. Many of the points in here will be helpful for probation practitioners in terms of increasing knowledge and awareness of suicide and its causes. The chapter also touches on the consequences of suicide for prisoners, staff and bereaved families something which has received very little attention in probation research. The remaining chapters are based on interviews with experts in the field which the author combines with a case study approach to a series of suicides that occurred at HMP Woodhill and analysis of Prisons and Probation Ombudsman (PPO) reports and Prevention of Future Deaths (PFD) reports. The book uses this range of sources to draw out what happens after a prison suicide and what might be done more effectively. Tomczak covers different groups' experiences of the scrutiny processes that occur after a death in prison and combines these interviews with analysis of the common findings from such investigations. In an attempt to explore why so many repeat recommendations are not implemented, Tomczak argues that there are too many 'directors and detectors' who highlight what has gone wrong and what needs to happen next but an insufficient number of 'effectors' to put those recommendation into practice. This leads to a call for some form of abolition with the final section of the book focusing less on suicide prevention and post-suicide investigation and more on creating a system which sends fewer people with mental ill health, drug and alcohol dependency to prison in the first place.

Suicides in prison have long been the concern of practitioners, policymakers and academics. Thanks to a relatively high level of scrutiny, we have a much better understanding of why people take their own life when in custody than was the case 20 years ago. We have much less knowledge about whether the responses to suicides in prison are appropriate and what they achieve. Whilst Tomczak's book, which seeks to address this gap in knowledge, is overwhelmingly focused on prison it offers some useful lessons for probation practice. The context of the book is stark. 87 people took their own life in prison in the year to September 2018 and the number of people dying in prisons has, since 2013 been on the rise despite a small dip in 2017/18. For comparison, there were 955 deaths of people on the probation caseload in the year 2017/18 with around one third being self-inflicted (one third of deaths were as a result of a 'natural' cause and the remaining third are recorded as unknown cause) (Ministry of Justice,

2018). The number of deaths has increased in the last 8 years and self-inflicted deaths are over-represented in the probation caseload. This rate is even higher amongst women. When compared to 2014/2015 the number of people dying after leaving prison has increased fourfold whilst the caseload has 'only' doubled.

Suicides in prison can, depending on the circumstances, be followed by a clinical review, a police investigation, PPO investigation and an inquest. There is a significant gap between what happens in prison and the process in probation where there is an internal review conducted by the responsible officer and their senior probation officer. Our analysis of these reviews suggested that very little lesson learning takes place after someone under probation supervision dies (Gelsthorpe et al., 2012) partly because the forms were cursorily filled in. We also noted a defensive tone and very little evidence of the reviews being considered as a corpus of information which might be used to explain why so many people on probation take their own life. In the prison context, an 'effective' investigation involves a range of measures including identifying those responsible for the death. This is likely to be unfeasible - or at least more difficult - in a community setting but there is scope for thinking about how we might go about strengthening lesson learning processes when people die under probation supervision. In Tomczak's analysis of post-suicide investigations there are two key themes to highlight: 1) that they often come to the same conclusion and 2) that recommendations are rarely put into practice. Tomczak's analysis points to the importance of the structures which hinder suicide prevention work in prisons - high workloads and organisational change are key factors in many post-suicide investigations; themes which are all too familiar to probation staff. It may be that similar conclusions can be drawn from an analysis into deaths under probation supervision but we simply do not know. If these issues are relevant then the findings from such investigations can be become a powerful case for better resourcing of community services and more stability.

Tomczak also considers the important issue of how front-line practitioners and families experience the range of post-suicide investigations in prison. Police investigations were seen to be prompt - a positive - but also perfunctory and insufficiently interested in corporate harm such as health and safety breaches. Ombudsman investigations, on the other hand, were seen to be more positive - an opportunity to 'get things off your chest' - but also long and stressful for both bereaved families and staff. Inquests are lengthy and difficult for all involved. They can also be expensive for bereaved families following cuts to legal aid. This is, then, about how post-suicide investigations are underpinned by good intentions - holding prisons to account, improving policy, providing access to justice for bereaved families - which, on the whole, fail to manifest. Rather, they place an undue burden on staff which, in the words of Tomczak, 'should not be underestimated' (105). She stresses the important point that prison staff have limited agency and the extent to which they are scrutinised following a suicide should take this into account. There are some key lessons in here for anyone who might be conducting a review of deaths in the criminal justice system such as the Ministry of Justice (2019) which said it would do so in its response to the Health and Social Care Committee's report on Prison Health (Health and Social Care and Committee, 2018).

This book is prison-focused but its relevance to probation should not be underestimated. As readers of *Probation Journal* know, following Offender Rehabilitation Act 2014, the vast majority of people who are in prison end up under probation supervision at some point and the book provides a useful reminder of the harms that imprisonment causes. The roll out of the Offender Management in Custody project will see more probation staff working in prisons and thus more probation staff will experience prison suicide

and the investigations that ensue. More importantly, the proportion of people who die by suicide under probation supervision is also in need of attention. As already stated, people on probation are more likely to die by suicide than people in the general population and those in prison. The self-inflicted death rate of people leaving prison is particularly high and the risk of women on probation dying by suicide is 30 times higher than women in the general population (Phillips et al., 2018). We have argued elsewhere (Phillips et al., 2019b) that current policy means that these deaths are currently missing, ignored and considered unimportant. There is a need to recognise the possible effect of being on probation when people die, so much so that these deaths could be seen to engage human rights legislation (Phillips et al., 2019a). There needs to be more in the way of investigations and lesson learning following some of the deaths of people on probation.

Much can be learnt from this book if more is done to investigate when people on probation die. Firstly, probation staff have limited agency and probation providers cannot be solely responsible for people on the caseload - this is even more so the case in probation than in the prison context. Thus, the focus of post-death reviews and investigations should not be about attributing blame - individual Responsible Officers are unlikely to be responsible for the death of a service user. Rather, investigations should be about seeking to identify systemic problems which might be hindering practitioners' ability to prevent suicide: this might be inadequacies in training, risk assessment procedures or issues around data collection. There is a small body of knowledge about who is most likely to die whilst under probation supervision (Borrill et al., 2017; Cook and Borrill, 2015; Mackenzie et al., 2018) but more needs to be done and doing more reviews and investigations will augment our understanding in this area. The range and number of investigations into prison deaths means we have a good understanding of why people die in prison. There is nothing to say that something similar for people on probation won't be equally as illuminating. Secondly, Tomczak reminds us that, were more investigations to take place after the death of a service user, there needs to be a concomitant increase in the number of 'effectors': there is little point in enhancing systems for detecting problems if no one can implement the solution. Thirdly, Tomczak discusses the way investigations can facilitate access to justice for bereaved families through PPO investigations and inquests. There is very little opportunity for bereaved families of people who die whilst on probation to have similar levels of access to justice and this is something which needs serious consideration. Finally, Tomczak highlights the need to ensure that any such investigations do not place an undue burden on staff who are already inspected, audited and have their work 'quality assured' on a regular basis. Post-death investigations should be designed to improve policy and practice and enhance access to justice for bereaved families but not at the expense of staff wellbeing and their ability to make defensible decisions based on evidence, high quality education and up to date training.

Tomczak's book covers an under-explored element of penal policy and the criminal justice system. The book will be of interest to those who work in and alongside prisons as well as researchers and students of penal policy who have a particular interest in suicide and systems of accountability. I would also urge all those who have a 'director', 'detector' or 'effector' role in the system to read the book and act on the recommendations contained therein. By bringing the voices of prison staff, stakeholders and families together the book makes a strong argument for more effective ways of 'doing' post-suicide investigation, implementing subsequent findings and reducing the number of people who die from otherwise preventable causes. But it is also the case that many of the findings and recommendations can be applied to the field of probation and would, if done properly, have the effect of reducing the number of people who die whilst under supervision.

References

Borrill J, Cook L and Beck A (2017) Suicide and supervision: Issues for probation practice. *Probation Journal* 64(1): 6–19. DOI: 10.1177/0264550516677770.

Cook LC and Borrill J (2015) Identifying suicide risk in a metropolitan probation trust: Risk factors and staff decision making. *Legal and Criminological Psychology* 20(2): 255–266. DOI: 10.1111/lcrp.12034.

Gelsthorpe L, Padfield N and Phillips J (2012) *Deaths on Probation: An Analysis of Data Regarding People Dying under Probation Supervision ; a Report for the Howard League for Penal Reform*. London: Howard League for Penal Reform.

Health and Social Care and Committee (2018) *Prison health: Twelfth Report of Session 2017–19*. HC 963, November. London: House of Commons. Available at: https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/963/963.pdf.

Mackenzie JC, Cartwright T and Borrill J (2018) Exploring suicidal behaviours by probation clients-a qualitative near-lethal study. *Journal of Public Health (Oxford, England)* 40(1): 146–153. DOI: 10.1093/pubmed/fdx005.

Ministry of Justice (2018) *Deaths of Offenders in the Community, annual update to March 2018*. London: Ministry of Justice. Available at: https://www.gov.uk/government/statistics/deaths-of-offenders-in-the-community-annual-update-to-march-2018 (accessed 15 February 2019).

Ministry of Justice (2019) *Government response to the Health and Social Care Committee's inquiry into prison health*. London: Ministry of Justice.

Phillips J, Padfield N and Gelsthorpe L (2018) Suicide and community justice. *Health & Justice* 6(1): 14. DOI: 10.1186/s40352-018-0072-7.

Phillips J, Gelsthorpe L and Padfield N (2019a) Deaths while under supervision: what role for human rights legislation? *Political Quarterly*.

Phillips J, Gelsthorpe L and Padfield N (2019b) Non-custodial deaths: Missing, ignored or unimportant? *Criminology & Criminal Justice* 19(2): 160–178. DOI: 10.1177/1748895817745939.

Tomczak P (2019) *Prison Suicide: What Happens Afterwards?* 1st ed. Bristol University Press. DOI: 10.2307/j.ctv80cb5f.